Welcome to Austin College! These forms are both required and time-sensitive. Failure to complete the required information could affect your ability to move into your residence hall, participate in on-campus activities, and attend class.

The following items are required for new students:

- Personal Family History Form
- Physical Examination Form
- Immunization Form
- Mental Health History Form
- Disability Accommodations Form
- Authorization Form
- Waiver/Enrollment Instructions

### PERSONAL AND FAMILY HISTORY

**Personal and Family History:** Please complete the form.

### PHYSICAL EXAMINATION FORM

**Physical Examination:** A licensed Physician, Nurse Practitioner or Physician’s Assistant must complete and sign the Physical Examination form. Health Services will accept either the physical form attached or the Austin College Athletics Pre-Participation Physical Evaluation form. [http://www.acroos.com/information/trainingforms/Physical_Form.pdf](http://www.acroos.com/information/trainingforms/Physical_Form.pdf)

### IMMUNIZATION FORM

**Immunization Record:** Your physician or their representative must complete and sign the immunization information. Note: Some immunizations are required, others are strongly recommended. A copy of school records immunizations will suffice, providing it meets all of our requirements.

You may not move on campus, attend class, or participate in intercollegiate athletics without documentation of meningococcal (MCV4) vaccination 10 days prior to arrival on campus (see immunization page).

*Failure to complete immunizations will result in weekly fines and/or impact your ability to register for the next semester.*

### MENTAL HEALTH HISTORY FORM

**Mental History Form:** Please complete the form.

### DISABILITY ACCOMMODATIONS FORM

**Disability Accommodations Form:** Students with documented disabilities who wish to utilize classroom accommodations are required to register with the College through the Office of the Vice President for Student Affairs. It is the student’s responsibility to provide written documentation of the disabling condition, the impairment(s) the condition causes, and recommended accommodations. Determination of eligibility for services and of appropriate accommodations is made on an individual case-by-case basis. Please attach any support documents.

### AUTHORIZATION SIGNATURE AND EMERGENCY CONTACT FORM

Please review and sign. All areas must be completed and signed by the student. If the student is less than 18 years of age at the start of the semester, the form must be signed by both the parent/legal guardian.
STUDENT HEALTH INSURANCE

All Austin College students/teaching assistants (full or part-time) are required to have medical insurance that is currently active. Student health insurance is available if you do not have other sources of health insurance.

You are required to upload copy of front and back of insurance card to waive student health insurance or to enroll if insurance is needed. You will be notified by when this task is available.

Failure to complete this task and have an approved waiver prior to the due date will result in the cost of the insurance being billed to your student health insurance.

STUDENT ATHLETES

You are encouraged to carefully check your family’s insurance policy. If it does not cover intercollegiate athletics, it is recommended that you purchase the student insurance plan. If you choose to use your family’s insurance plan, you are required to turn your medical insurance information in to our office and to the Athletic Department separately. Failure to complete the waiver will result in your enrollment for the student health insurance.

Athletes are not permitted to participate in their team’s activities prior to submission of all the required forms. You must turn your documents into our office in addition to uploading them on for the Athletics Department. Please contact Julie Travis at jtravis@austincollege.edu or call 903-813-2499, if you have any questions. The Athletic Trainer can be reached at 903-813-2514.

Uploading your forms to SportsWare
All other questions regarding your health packet can be answered by calling Adams Center at 903-813-2247 or emailing health@austincollege.edu.

RETURNING HEALTH PACKET

Email: You may request a secure email link by calling 903-813-2247 or sending an email to roowellness@austincollege.edu.

Mail: Health Services
Austin College
900 N. Grand Ave, Ste. 61629
Sherman, Texas 75090

Fax: 903-813-3188

Phone: 903-813-2247
# Personal and Family History

Information on this page will be used by Health Services and is regarded as confidential. Release to other College personnel would be strictly on a need to know basis.

Student Name ________________________________________________________ Date________________________
DOB ___________ Sex ___________ Phone ___________

## Parent or Guardian

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Home Phone (____)</th>
</tr>
</thead>
<tbody>
<tr>
<td>City _______</td>
<td>State ______ Zip ______</td>
</tr>
</tbody>
</table>

Father: □ Living □ Deceased

<table>
<thead>
<tr>
<th>Age at death</th>
<th>Cause</th>
<th>Occupation</th>
</tr>
</thead>
</table>

Mother: □ Living □ Deceased

<table>
<thead>
<tr>
<th>Age at death</th>
<th>Cause</th>
<th>Occupation</th>
</tr>
</thead>
</table>

Siblings:

<table>
<thead>
<tr>
<th>Number Living</th>
<th>Number Deceased</th>
<th>Cause</th>
</tr>
</thead>
</table>

## Family Medical History

Have any of your blood relatives had any of the following?

- □ Allergies
- □ Arthritis
- □ Asthma
- □ Cancer
- □ Diabetes
- □ Emotional Illness
- □ Heart Disease
- □ High Blood Pressure
- □ Kidney Disease
- □ Seizure Disorder
- □ Tuberculosis

## Personal Medical History

Have you now or in the past had any of the following conditions?

- □ Anorexia
- □ Bulimia
- □ Anxiety
- □ Depression
- □ Arthritis
- □ Asthma
- □ Bleeding Disorder
- □ Dental/Gum problems
- □ Diabetes
- □ Menstrual problems
- □ Headaches
- □ Migraine
- □ Murmur
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Heart Disease

Specify: ________________________________

## Allergies to Medicine

- □ Hypoglycemia
- □ Kidney Disease
- □ Neurological problems
- □ Numbness/Tingling
- □ Seizures/Blackouts
- □ Skin Diseases
- □ Thyroid Disease
- □ Tuberculosis
- □ Wear Hearing Aid
- □ Other

## Diseases

- □ Chicken Pox
- □ Hepatitis
- □ HIV
- □ Malaria
- □ Measles
- □ Mononucleosis
- □ Mumps
- □ Rheumatic Fever
- □ Rubella
- □ Rubeola
- □ Scarlet Fever

## Allergies to Food/Other

- □ Foods
- □ Seasonal Pollens
- □ Wasp/Bee Stings
- □ Other

## Orthopedic History

Injuries/Fractures

- □ Gall Bladder
- □ Hernia Repair
- □ Tonsillectomy
- □ Other

## Surgeries

- □ Gall Bladder
- □ Hernia Repair
- □ Tonsillectomy
- □ Other

Do you have a medical disability? □ No □ Yes-Explain ________________________________

Do you have special dietary needs? (Check yes here to be contacted by Dining Services.) □ No □ Yes

Are you receiving any ongoing treatment from a physician? □ No □ Yes-Explain ________________________________

Are there medications involved? □ No □ Yes-List ________________________________

Is local physician follow-up needed? □ No □ Yes

Is there any additional information Health Services should know in order to provide you with better health care?

__________________________________________________________________________

Return Forms to Health Services 61629
### Physical Examination

( Must be completed by a Physician, Nurse Practitioner or Physician’s Assistant)

*Athletes may submit completed Pre-participation Physical Evaluation*

**TO THE EXAMINING PROVIDER:** Please review Personal and Family History and complete this form. Also, note that a signature is required from your medical provider.

**STUDENT NAME:** ___________________________  **DOB:** ____________  

- [ ] Male  
- [ ] Female

<table>
<thead>
<tr>
<th>Pulse: ______</th>
<th>Blood Pressure: ______</th>
<th>Height: ______</th>
<th>Weight: ______</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Ears, Nose and Throat</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Metabolic/Endocrine</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
</tr>
</tbody>
</table>

- Does student plan to participate in an NCAA Intercollegiate athletic team sport?  
  - [ ] Yes  
  - [ ] No

  If yes, which sport? ______________________

- If this student is on medication, give name and dosage.  
  _______________________________________

- Is this student under treatment for any physical condition?  
  - [ ] Yes  
  - [ ] No

  Explain ______________________________________

- Any recommendations for care of this student?  
  ______________________________________

- Is this the student’s first visit to your office?  
  - [ ] No  
  - [ ] Yes

- Recommendations for physical activity:  
  - [ ] Unlimited  
  - [ ] Limited  
  - [ ] Temporary  
  - [ ] Permanent

  If limited, explain _____________________________

- Date of examination _______________________

- Signature of Provider _______________________

- Printed Name of Provider ____________________

- Street Address _____________________________

- City, State, Zip ____________________________

- Phone (_______) ___________________________
Immunization Record

Student Name: __________________________ Date of Birth: __________________________

The Immunizations Required for Students Entering Austin College Are Listed Below

Persons seeking an exemption for religious reasons or reasons of conscience need to follow the State of Texas guidelines listed on their website https://webds.dshs.state.tx.us/immco/affidavit.shtml or link from Austin College Health Services site. If exemption is requested for medical reasons, an affidavit or certificate from your physician stating the medical risk and which immunizations cause this risk must be submitted including physician’s signature, and stamp from clinic or office. Records from physician’s office, health departments, or schools will be accepted in lieu of signature below. Make a copy of this record for yourself.

MENINGOCOCCAL (MCV4)
***Required by Texas State Law, if under 22 years old**

Booster required if >5 yrs before start of semester

TETANUS-DIPHTHERIA-PERTUSSIS (Tdap)
 Required within the past 10 years

Date of Last Dose

MEASLES-MUMPS-RUBELLA (MMR)
Dose 1 – given at 12 months of age or after

Dose 2 – given at 4 years of age or later

POLIO

Date of Last Booster

VARICELLA (not required if has a history of Chicken Pox Disease)

Dose 1 – given at 12 months of age or after

Dose 2 – given at 4 years of age or later

History of Chicken Pox Disease □ Yes □ No Year____________________

HEPATITIS A
Dose 1

Dose 2 – given 6 months after the first

HEPATITIS B
Dose 1

Dose 2 – given 1 month after first dose

Dose 3 – given 6 months after first dose

TUBERCULOSIS (TB TEST) REQUIRED WITHIN THE PAST 1 YEAR
Any of these tests are accepted, TSpot, PPD, or chest X-ray. BCG vaccine is not acceptable.

1. TSpot
   Date of Test __________ Result __________

2. PPD test
   Date Placed __________ Date Read __________ Results __________

3. If positive TB test a chest x-ray is required.
   Date and result of check x-ray __________________________ Date Result __________________________

NOT REQUIRED

Meningococcal B (MenB) – Please note MCV4 is required (see above). Date ________________

Human Papillomavirus (HPV) - The Center for Disease Control and the American Academy of Pediatrics highly recommend this 3 dose series.

Date____________________ Date____________________ Date____________________

Health Care Provider Signature __________________________ Date ________________
Mental Health History

Adjustment to college is a challenge for all students. Students with psychological issues may experience more significant adjustment problems. For this reason, college personnel request that students disclose information to promote continuity of care, as well as informed intervention should a crisis occur, particularly during the first semester on campus.

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed form to Health Services, using the enclosed return envelope.

Student Name______________________________DOB______________Date_____________

Describe any medical or mental health problems or conditions that have required professional psychological care.

________________________________________________________________________

<table>
<thead>
<tr>
<th>Have you had or experienced any of the following:</th>
<th>Yes</th>
<th>No</th>
<th>Age or Dates of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression treated professionally.............................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Anxiety disorder.........................................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Eating disorder............................................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Bipolar disease............................................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Asperger’s Disorder (autism spectrum disorder)..................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder.......................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Anger management issue..................................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Post-traumatic stress disorder (PTSD)...............................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>ADD/ADHD.................................................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Suicide attempt............................................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Suicidal ideation..........................................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Sleep disorder............................................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Panic disorder.............................................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Learning disability........................................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Anti-social or conduct disorder.......................................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Alcohol or substance abuse or dependence........................</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
<tr>
<td>Other (please specify)________________________________________</td>
<td>□</td>
<td>□</td>
<td>__________________________</td>
</tr>
</tbody>
</table>

Are you now taking or have you ever taken medication for any of the above? □ □ __________________________
(Specify medication and dates)

________________________________________________________________________

Do you intend to begin or continue medication or counseling during college? □ □ __________________________
Have you been hospitalized for a psychiatric disorder? □ □ __________________________
Have you been treated for alcohol and/or drug addiction? (Specify dates) □ □ __________________________
Disability Accommodations

Student Name: ____________________________________________ Date: __________________________

DOB: _________________________ Phone Number: _______________________________

The Academic Skills Center, located in room 211 of the Wright Campus Center, addresses the academic needs of students with documented physical, psychological and learning disabilities.

Accommodations are provided in accordance with the Americans with Disabilities Act Amendments Act, ADA-AA, for eligible students upon request. Eligible students must provide documentation that appropriately substantiates the need for requested accommodations.

Once you file appropriate documentation, you will meet with the Director of the Academic Skills Center to identify accommodations and other suitable academic strategies. At the beginning of each semester, you will be required to fill out paperwork with the director to request the use of accommodations for courses in which you are currently enrolled.

Please complete the following questions so that the College will have an idea of the services you may need. All information disclosed on this form will be kept confidential and will be shared with appropriate college personnel on a need-to-know basis only.

If you think you might need to request accommodations at any time while at Austin College, please complete this form and send a copy of any documentation you have to:

900 North Grand, Suite 61629, Sherman, TX 75090.
903-813-2228

For more information about disability accommodations or the Academic Skills Center, please visit http://www.austincollege.edu/campus-life/academic-skills-center/

You may also contact us at ASC@austincollege.edu or call (903) 813-2454.

☐ I do not require any accommodation.

1. What is the nature of your disability?

2. How and when was your disability diagnosed and documented?

3. What types of accommodations have you used?

4. What accommodations are you requesting at Austin College?

5. Are there any new accommodations you anticipate requesting? If so, please specify.
Return Forms to Health Services 61629
900 North Grand, Suite 61629 Sherman, TX 75090-4400

Student Name: ____________________________________________Student ID: ________________
DOB: ________________________________________Phone Number: _____________________________

EMERGENCY NOTIFICATION

<table>
<thead>
<tr>
<th>PRIMARY NAME</th>
<th>RELATIONSHIP</th>
<th>DAY PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CELL PHONE</th>
<th>EVENING PHONE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SECONDARY NAME</th>
<th>RELATIONSHIP</th>
<th>DAY PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CELL PHONE</th>
<th>EVENING PHONE</th>
</tr>
</thead>
</table>

AUTHORIZED

▪ I authorize the Health Services at Austin College to administer treatment by licensed nursing and medical personnel for emergency and routine health care. This would include assessment, treatment and, if necessary, referral or hospitalization. If health care is needed in the absence of Health Service personnel, a college representative may choose local health services on my behalf.

▪ I authorize disclosure of health care information related to my medical history, diagnosis, treatment, or prognosis in case of Emergency Room care or hospitalization to the following AC personnel:
  ▪ Vice President for Student Affairs and Athletics
  ▪ Dean of Students
  ▪ Director of Health Services
  ▪ Director of Counseling Services
  ▪ Professional Residence Hall Staff
  ▪ Athletic Trainer

____________________________________________________________________________ ___________________________
Student Signature (& Guardian if student is under 18 years of age)   Date
Austin College is pleased to offer two ways to manage your required health insurance coverage. The first option is if you currently active medical insurance, you may waive-out (decline) the student health insurance. The second option is if you do not currently have health insurance you should enroll in the college student health insurance. Premiums for the student health insurance are below.

**All students must login to the AHP website and waive/enroll in the student health insurance.** Failure to do complete a waiver prior to the due date will result in your account being charged and enrolled in the plan.

<table>
<thead>
<tr>
<th>Waiver/Enrollment Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/1/2020 – 7/31/2021</td>
</tr>
<tr>
<td>$2297.00</td>
</tr>
</tbody>
</table>

*You can pick up coverage at any time during the year with a “Qualifying Life Event” by contacting our office.

*ALL students must login to this system and follow the steps to EITHER waive the coverage or to enroll.*

---

**To Waive the of Student Insurance Plan**

*If you currently have an active medical insurance plan and covers you for the whole academic year*

**Step 1:** Please have your medical insurance card on hand. Go to this link [http://www2.academichealthplans.com/school/2351.html](http://www2.academichealthplans.com/school/2351.html)

**Step 2:** Your *user ID* is your *AC Student ID* with one leading “0” in front (i.e. 035####).

**Step 3:** Your *password* is your *birthdate* (i.e. 07051978)

**Step 4:** After logging-in, click on the red button to submit waiver. Complete the waiver form using the information from your medical insurance card. DO NOT leave any blanks. You can type N/A if it does not apply.

**Step 5:** Upload a copy of the front and the back of your insurance card to the form.

**Step 6:** Click “submit” at the bottom of the form when you are done. You should see confirmation appear that you have waived.

* If after following these steps, you are unable to log into your AHP account to waive, please contact AHP Customer Service at (855) 370-7215.

---

**To Enroll in Student Insurance Plan**

*If you do not have a currently active medical insurance for the academic year.*

**Step 1:** Go to this link [http://www2.academichealthplans.com/school/2351.html](http://www2.academichealthplans.com/school/2351.html)

**Step 2:** Your *user ID* is your *AC Student ID* with one leading “0” in front (i.e. 035####).

**Step 3:** Your *password* is your *birthdate* (i.e. 07051978)

**Step 4:** Click on the green “One Click Enrollment” button.

**Step 5:** Read the information and type your initial to e-sign your consent

**Step 6:** Click “submit” at the bottom of the form when you are done. You should see confirmation appear that you have waived.

* If after following these steps, you are unable to log into your AHP account to waive, please contact AHP Customer Service at (855) 370-7215.